Berkshire Healthcare NHS Foundation Trust

RWX

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RWXX3	St Marks Hospital	St Mark's Hospital	SL6 6DU
RWXX1	Wokingham Community Hospital	Wokingham Community Hospital	RG41 2RE
RWX85	Upton Hospital	Upton Hospital	SL1 2BJ
RWX58	Church Hill House	Church Hill House	RG12 7FR
RWX86	West Berkshire Community Hospital	West Berkshire Community Hospital	RG18 3AS

This report describes our judgement of the quality of care provided within this core service by Berkshire Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Berkshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Berkshire Healthcare NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service GOOD l

Overall, this core service was rated as good. We found community services for adults was good for all the key questions of safe, effective, caring, responsive and well-led.

Our key findings were:

- Staff recorded incidents on the electronic reporting system with shared learning across the service. There was a strategic approach to reducing harm where there were concerns, as in the case of pressure ulcers.
- Staff adhered to infection prevention and control procedures, the trust used an audit programme to monitor and improve practice.
- Staff were able to identify safeguarding issues and followed the safeguarding procedures to report concerns.
- Staffing levels had improved across the service in recent months and community nursing teams worked collaboratively to share referrals, prioritise workloads and meet demand.
- Risk assessment was used to inform care; however, we found there were inconsistencies in staff practice in the frequency of review some assessments, such as for pressure ulcers.
- Care plans were evidence based with patient centred outcome goals.
- Staff were competent for the roles they undertook and the majority of staff had received an appraisal in the last year. Supervision was available but the uptake varied across the teams.
- There was excellent multi-disciplinary working. Staff worked collaboratively to understand and meet the needs of patients, particularly those with long-term conditions.
- There were appropriate systems and processes in place for the referral, transfer and discharge of patients from services.
- Consent was sought from patients prior to care or treatment being provided. Not all staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Patients received compassionate care that respected their privacy and dignity, with patients involved in decisions made about their care.
- The planning and delivery of services took into account the diverse needs of the local population and those in vulnerable circumstances. The reconfiguration and integration of some services had taken place for the trust to be able to be more responsive to patients with complex needs.
- Delayed transfers of care were a priority area for the trust to address. Work was taking place with partner agencies to improve the situation.
- There was a clear vision and strategy for community health services for adults, in line with the trust vision and goals. Most teams had developed their own business plans to correspond with the directorate plan.
- Clear management and governance structures were in place through meetings to monitor performance and service risks. There was good local leadership throughout the various teams with an open, caring and supportive culture.
- The trust used feedback from patients to monitor the quality of the service and to inform change.
- There were good examples of innovation to improve patient care and wellbeing. Cost improvement programmes were in use to ensure sustainability of services

Summary of findings

Background to the service

Information about the service

Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services to a population of around 900,000 within Berkshire. The service is provided in an operational locality structure, which is aligned, with the six local authorities. In East Berkshire this consists of Slough, Bracknell Forest and the Royal Borough of Windsor and Maidenhead, in West Berkshire, the three local authorities are Reading, West Berkshire and Wokingham. Berkshire East CCGs and Berkshire West CCGs, together commission services from Berkshire Healthcare Foundation Trust.

Community health services aim to support people in staying healthy and to help them manage their long-term conditions. This is in order to avoid hospital admission and support patients at home immediately following discharge from hospital. The range of services provided by the trust included single speciality services such as community nursing, musculoskeletal physiotherapy and speech and language therapy. There were also specialist services such as respiratory, heart failure and continence clinics as well as multidisciplinary teams. There were three intermediate integrated care teams and an early supported discharge service for stroke patients.

Services were provided at multiple sites including community hospitals, clinics, in patients' own homes and residential and nursing homes.

Community services work closely with acute services, commissioners, adult social care services and GPs.

Our inspection team

Our inspection team was led by:

Chair: Dr Ify Okocha, Medical Director Oxleas NHS Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities

and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team that inspected community health services for adults included CQC inspectors and a variety of specialists including a community matron, occupational therapist and a district nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of NHS trusts.

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting Berkshire Healthcare NHS Foundation Trust, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. We carried out an announced visit over three days between 8 December 2015 and 10 December 2015.

Summary of findings

During the visit, we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. Specifically for this core service, we visited nine district nursing teams across East and West Berkshire, musculoskeletal physiotherapy services in East and West Berkshire, cardiac and respiratory specialist service, diabetic service, integrated intermediate care team, continence service, early supported discharge service , nutrition and dietetic service , speech and language service and assessment and rehabilitation centre. During our visits, we spoke with 67 staff including community nurses, physiotherapists, speech and language therapists, dietician, nurse specialists in respiratory, cardiac and diabetes, community matrons, healthcare assistants, administrators, diabetic eye screening technician and service managers.

We accompanied staff on home visits and in clinics; we spoke with 29 patients and relatives who used the services, we observed 11 interactions between staff and patients and reviewed 15 care records.

What people who use the provider say

We spoke with 29 patients and carers. We spoke with patients and carers at clinics, at a rehabilitation class, during home visits and on the telephone. Without exception, patients and carers praised the quality of care and treatment they received from all staff working in community services for adults.

They spoke highly of the way staff involved them in the decisions about their care and treatment. All patients felt fully informed about their proposed plan of care and felt they could ask questions if they were uncertain or wished for additional information.

Patients told us staff were caring, understanding and sympathetic to their needs, always trying to resolve issues and concerns where they could. Staff were particularly supportive of patients with complex or long-standing conditions.

The 'Friends and Family' supported these findings data, which showed the majority of patients, would be extremely likely or likely to recommend the service to a family member or friend.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that the service reviews the use of the pressure ulcer risk assessment tool.
- The trust should ensure that equipment is maintained and fit for purpose
- The trust should ensure that staff are aware of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The trust should ensure that staff are supported to attend clinical supervision and attendance is monitored.

Berkshire Healthcare NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Summary

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good.

Staff followed incident reporting procedures and received feedback following incidents. Learning from incidents was shared across the service. Staff adhered to infection prevention and control procedures and staff had completed the appropriate training. An infection control audit was followed, to monitor and improve practice.

The majority of staff were up to date with mandatory training. Staff were able to identify safeguarding issues and followed the safeguarding procedures to report concerns.

Staffing levels had improved across the service in recent months and community nursing teams worked collaboratively to share referrals to prioritise workloads and meet demand.

Staff took time to ensure all records were up-to-date as patients had paper-based records in their home and a centralised electronic record. Risk assessments were completed. However, we found there was inconsistency in practice in the frequency of review of assessments, such as for pressure ulcers.

Equipment was well maintained. However, in one team, there was a significant proportion of equipment, which needed a service, and this was overdue. Some equipment may have been overdue for a service. It was not clear from any records when equipment was due for this. This could present a risk to patient safety.

Detailed findings

Safety performance

- The trust used the NHS safety thermometer to monitor harm free care. The NHS safety thermometer records the presence or absence of four harms, including pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter and new venous thromboembolisms (VTEs).
- During September 2014 to September 2015, the number of new pressure ulcers per month decreased from 21 in

Good

Are services safe?

September 2014 to eight in June 2015. However, more recently the average was 15 per month. The prevalence of new pressure ulcers was similar to the national average.

- The trust aimed for a 20% reduction in avoidable grades three and four pressure ulcers (ulcers are graded according to the depth of skin and tissue damage, grade one superficial damage and grade four full skin thickness destruction) and 15% reduction in grade two. Across the trust, the target was achieved, except for grade two pressure ulcers in East Berkshire, where 127 were reported, against a target of 118.
- Between September 2014 and September 2015, the incidence of new catheter related urinary tract infections was lower than the national average in nine out of the last 13 months, with a monthly average of 0.27%, compared with national average of 0.3%. The prevalence of falls with harm was 0.5%, which was also lower than the national average of 0.6%.
- Across the trust, the average percentage of patients receiving harm free care was 93.3%, which was below the national average of 94.1%.
- Twenty seven serious incidents were reported by adult community services between September 2014 to October 2015.The majority of these incidents, specifically sixteen, related to grades three and four pressure ulcers and three related to falls.
- Safety performance data was discussed at all levels in the organisation, such as, at team meetings, locality patient safety and quality meetings and the quality executive group meetings.
- Incidents including pressure ulcers were reported on the monthly community-nursing scorecard.

Incident reporting, learning and improvement

- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse.
- All staff we spoke with were familiar with reporting incidents using the electronic online system. We saw incidents that had been reported and staff confirmed they received feedback.
- Pressure ulcers grade two and above were reported as an incident. In response to the higher numbers of pressure ulcers reported in 2014/15, the trust had developed a strategy group. A monthly report was produced, to monitor progress. Learning from significant incidents was reported to all localities. For example, investigations into pressure ulcers identified patients were not always using prescribed equipment or not using it correctly. The trust had also identified pressure ulcer champions in each locality to provide support and disseminate key messages to staff. To inform patients, staff provided a laminated card, ''react to red', which provided advice to patients on preventing pressure ulcers.
- The trust recently introduced a bulletin, 'learning curve' to highlight learning from incidents and complaints.
- Staff said lessons learnt were highlighted at team meetings and clinical development meetings such as the district nursing forum.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. Staff had an awareness of duty of candour and their responsibilities. The incident reporting form had a link to further information about duty of candour, which prompted staff to take the appropriate action.

Safeguarding

- Staff were familiar with the trust's safeguarding procedures and knew how to recognise the signs of abuse. Safeguarding contact details for the trust team were on display in team offices as a visual reminder to staff.
- Staff were aware of how to recognise signs of abuse and what action to take if they suspected abuse. The district nurses said they contacted the safeguarding lead for advice when needed.
- We saw instances where staff had raised an incident and related safeguarding alert.
- Safeguarding adults and children training was part of the mandatory training programme for staff. Over 85% of staff in adult community health services had completed the training in October 2015; this met the trust target.

Medicines

Good

Are services safe?

- Staff followed medicines management policies (care and control of medicines (April 2015) and standard operating procedures were followed by staff when handling medicines. For example, transport of medicines (October 2015). Staff handled medicines appropriately in patients' homes and completed records accordingly.
- A system was in place to develop and monitor 'patient group directions' (PGDs) to ensure they were up to date and authorised appropriately. PGDs are instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs such as for drugs used in emergency and flu vaccines were used by community nurses, specialist services and physiotherapists to allow legal administration of specific medicines against agreed criteria.

Environment and equipment

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An external supplier was responsible for delivering equipment to the patients' home and provided equipment for patients' own use. Urgent equipment, for example, to avoid hospital admission was delivered the same day and repairs carried out within 24 hours: priority being given to those at greatest risk. However, staff told us patients often complained about delays in collecting equipment that was no longer required.

- Staff were able to seek advice on equipment from the specialist nurse for complex cases. The specialist nurse also conducted home visits if necessary to assess patients' needs.
- During our visits to community nursing offices and clinics, we observed equipment had been portable appliance tested to ensure it was safe to use.
- Individual teams had systems in place to log and monitor equipment which required servicing. Equipment was generally up to date with its service history which was indicated by an adhesive label on the equipment. However, in the cardiac and respiratory specialist service (CARSS) and musculoskeletal (MSK) physiotherapy service (West Berkshire) staff said delays to equipment servicing occurred due to the time when engineers attended. This did not always take account of when staff were in the office base or the equipment was in use.
- Staff in the respiratory team (part of CARSS), had identified 30 out of 65 pieces of equipment, such as oximeter, thermometer and blood pressure monitors, which were overdue a service, or not known if the service was overdue. A plan was in place to address and monitor the situation; however, this potentially posed a risk to patient safety.

Quality of records

- We reviewed 15 care records across different teams and at different locations within community services. The services and teams we visited used a combination of paper and electronic patient record keeping systems.
- Patients had paper records in their own home, which contained basic medical information about the patient and their care plan. Staff were seen to update care plans when relevant. Summary information on each visit was then transferred onto the electronic system. In general, they were easy to read and contained enough detail so that all specialities involved in the care of the patient were clear on the care plan and goals for the patient.
- Electronic records were kept secure. Staff used a personal login to access the electronic records system. Staff logged out of the system after use, to prevent unauthorised access to patients' records.
- Patients' records reviewed at the specialist services and early supported stroke discharge team were very comprehensive. Records contained initial assessments including medical and social history, social situation, cognitive abilities, risk assessment, activities of daily living and emotional and psychological factors. Care plans were in place and a goal attainment scale (GAS) was completed (GAS is a method of scoring the extent to which a patient's individual goals are achieved in the course of intervention.) Records were up to date and information was objectively recorded. Verbal consent to treatment was noted.

Good

Are services safe?

- Staff recognised the importance of keeping the information up to date on the system. However, they told us that due to connectivity problems and the time taken to complete records online, there was often a short delay to complete records.
- Until recently the trust used a generic record keeping tool to audit records annually. A new intranet based audit tool was introduced in November 2015, which could be tailored to the service requirements. However, results of the use of the new audit tool for all services were not yet available. The audit results for the West of Berkshire MSK service, conducted in May 2015, showed most areas of record keeping complied with the standards. There were some problems with records not being timed and failure to record discipline at each treatment. Actions were taken to address this.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean and tidy. There was access to hand sanitiser or hand washing facilities to limit the spread of infection between staff and patients.
- Cleansing detergent wipes were provided to clean equipment. Patient chairs were wiped clean and clinical areas had washable floors for ease of cleaning.
- During home visits we observed staff adhering to the trust 'bare below the elbows' policy and there was appropriate use of personal protective equipment, such as gloves and aprons, to reduce the risk of cross infection. We observed staff use sterile gloves when providing wound care. Staff in general cleaned their hands before and after seeing a patient.
- During a rehabilitation session, we observed that staff cleaned equipment with detergent wipes between patients use and at the end of the session.
- There was an annual infection prevention and control audit and monitoring programme in place. This covered a range of services and areas. For example, hand hygiene, equipment and catheter care.
- The results of the audit of patient equipment (which included cleaning of equipment in the musculoskeletal service) showed 100% compliance. An audit of urinary catheter care bundle (February to March 2015) assessed compliance with National Institute of Health and Care Excellence (NICE) quality standard. Those teams scoring less than 100% had action plans in place to address concerns.
- Quarterly hand hygiene audits showed over 90% compliance in all the areas we visited. A repeat audit of sharps handling and disposal of sharps in 2014/15 showed improvement on the previous year's results with the majority of community services scoring 100% or over 90%, except for two teams in East Berkshire, where areas of non-compliance were identified for follow up.

Mandatory training

- Mandatory training for staff was via a mix of e learning and classroom based sessions. Mandatory training for all staff included infection prevention and control, information governance, and safeguarding children and adults at risk.
- The Berkshire community nursing scorecard for October 2015 showed 93% of staff had completed their mandatory training, although some teams were slightly below the trust target of 85%.Overall for adult community health services the achievement was above the trust target of 85%.
- The trust learning and development system identified additional mandatory training requirements for staff dependent on their role and grade. For example, community nurses were expected to undertake training in medicines management and pressure ulcer management and prevention.
- Staff had access to their training record with email alert sent to the individual when training was due
- Attendance at training was monitored by managers and at locality patient safety and quality (PSQ) meetings.

Assessing and responding to patient risk

- Risk assessments were undertaken as part of the initial assessment when a patient was referred to the service. For example, during a first home visit we observed full initial assessments were undertaken including an assessment of risk of pressure ulcers (Waterlow), malnutrition universal screening tool (MUST), moving and handling and falls. For specialist services, assessments including additional subjective and objective measures were undertaken.

Good

Are services safe?

- We were told the Waterlow risk assessment was undertaken at a patient's first assessment and then repeated every three months and more frequently depending on the risk score and clinical judgement. There was no clear guidance on the frequency of the review of the Waterlow pressure ulcer risk assessment when the scores were high. District nurses across all teams were clear a review of the score would take place but the frequency varied when the score was high. Two community nurses told us the risk assessment would be repeated monthly. However, we saw two patients' records that had scored more than 20 ('very high risk') on the Waterlow scale and the risk, assessment was repeated no more frequently than three monthly.
- We reviewed the audit of records in October 2015, which showed 99% of records showed the MUST, and Waterlow risk assessments were completed every three months. However, the audit did not show the risk score and the expected frequency of repeating the Waterlow risk assessment.
- In East Berkshire, district nurses aimed to respond within 2 hours for patients with a blocked catheter. For patients at the end of life this was within 4 hours for urgent referrals and within 24 hours for routine referrals. In West Berkshire, staff aimed to respond to blocked catheters and end of life symptom control within 2 hours.
- We observed during a cardiac rehabilitation session, patients' status was assessed at specific points through the exercise programme. This was to ensure they were fit to continue at the same pace.
- We observed two district nursing staff handovers, which took place daily. Patients' needs were discussed and recommendations for referral to other services were made. For example, the community matron recommended referral to social services and the high technical equipment specialist for one patient. Feedback to the GP about another patient's change in condition was also highlighted to keep the GP informed.
- Emergency equipment was available. For example, in the facility where cardiac rehabilitation classes took place. Staff we spoke to had received training in cardiopulmonary resuscitation (CPR) and were aware of the procedure for getting assistance in an emergency.
- Staff used the alert system on the electronic recording system to record immediate risks, both medical and social for patients. This included recording of key codes to enable staff to access patient's homes. This meant that all staff had access to this information to help ensure staff and patient safety.

Staffing levels and caseload

- The community nursing teams in East Berkshire had experienced a high degree of staff turnover in the previous six months. The staffing situation had improved and experienced peers supported new staff. A member of one team which had undergone a significant number of staff changes in the previous six months, said "…We are now learning new ways of working, things have improved and there is more workload sharing…getting everyone united again."
- The community nurse scorecard for end of October 2015 showed sickness absence was above the 3% target in three out of six localities and there were vacancies of more than 10% in three out of six localities. One locality, Reading, had high rates of vacancies and sickness. This was managed across teams to meet service demand.
- All the localities used a triage system to allocate referrals. Newbury also operated an urgent care model where an allocated district nurse managed the urgent referrals. Different teams use the approach, which suited them to meet patients' needs.
- Some community nursing teams had introduced a locally developed colour coded capacity tool to establish the number of staff needed based on the number of units required for a task. One unit equated to 20 minutes. This allowed team leaders to see at glance the shifts when demand exceeded capacity and if neighbouring teams had capacity to assist. However, we were told band 6 district nurses completed the tool and if they were not available, the data was not uploaded. In two community nursing teams in East Berkshire where the tool was used, staff said it was helpful in allocating urgent work and supporting staff, who were working at full capacity. The use of the capacity tool was new to some teams and was being rolled out and tested across the trust. Where it was in use, it was reviewed weekly.
- Generally, community nursing teams operated on a daily handover and workload meeting to ensure referrals were allocated and responded to appropriately.

Good

Are services safe?

- Staffing in the musculoskeletal, cardiac and respiratory specialist services and intermediate care service had improved over the last month. This was evident as we spoke to a significant number of new staff across all services and the waiting time data we reviewed showed services were meeting their targets.

Managing anticipated risks

- The 2015 winter plan set out the arrangements for the management of system pressures during this time. These included the identification of the main risks and existing control measures, planning and action phases, roles and responsibilities and details of supporting plans and arrangements made with other agencies.
- Community nursing staff told us they had tried and tested procedures in place to ensure the most vulnerable patients were prioritised in cases of emergency. For example, in inclement weather or severe staff shortage, patients who required medication such as insulin would be prioritised.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as ''good''.

Staff provided care to patients based on national guidance, such as National Institute for Health and Care (NICE) guidelines. Care plans were evidence based and outcome goals patient centred. Patient outcomes were monitored and reviewed by individual services.

Staff were competent for the roles they undertook and there was evidence of appropriate supervision in place for staff. The majority of staff had received an appraisal in the last year.

Staff assessed patients' pain needs and managed this appropriately. There was excellent multi-disciplinary working. Staff worked collaboratively to understand and meet the needs of patients, particularly those with long-term conditions.

There were appropriate systems and processes in place for the referral, transfer and discharge of patients from services.

Consent was sought from patients prior to care or treatment being provided. However, not all staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Detailed findings

Evidence based care and treatment

- Staff provided care to patients based on national guidance, such as National Institute for Health and Care Excellence (NICE) and from the relevant professional body.
- Introduction of NICE guidance was through the trust clinical effectiveness group and a system was in place to implement and monitor implementation of NICE guidance.
- NICE guidelines on the prevention and management of pressure ulcers 2015 were used to develop a care pathway. Staff were aware of NICE guidance and we saw an example where a community nurse showed an anxious patient the NICE guidance on microbial washing of wounds, to allay their fears of washing the wounds. This resulted in on going good compliance with washes and reduction in pain reported by the patient.
- At another visit, staff provided catheter care in accordance with the Berkshire pathway.
- The cardiac rehabilitation programme provided data for the national audit of cardiac rehabilitation. It was working towards accreditation.
- We spoke with specialist teams across the trust including the early supported discharge stroke service and rehabilitation and assessment clinic (RACC). These teams used best practice guidance to inform the care and services offered. For example, the early supported discharge team was established to promote early discharge of a patient with stroke from hospital by providing support from therapists. Patients received intensive support for approximately six weeks, if required, to help them with their rehabilitation in their own home.
- The RACC offered urgent multidisciplinary assessment, including a medical assessment. Examples of the work offered by the RACC was evidence based intensive support by speech and language therapists and physiotherapists for patients with Parkinson's disease.
- The diabetes services in East and West Berkshire were accredited for the education courses they offered. For example, East Berkshire had 'quality institute for self-management education and training' (QISMET) accreditation and West Berkshire was accredited with 'X-PERT Health.'
- The diabetic eye screening service implemented changes to their procedures in line with guidance from the national diabetic eye-screening programme.

Pain relief

Good

Are services effective?

- The physiotherapy musculoskeletal service offered a wide range of physiotherapy techniques to reduce pain including manual treatment, exercises and acupuncture. Physiotherapists could also refer the patient back to their GP to make changes to analgesia if necessary.
- We saw pain control charts were completed. Patients told us that they were asked about any pain they were experiencing and steps were taken to manage this and we observed this on visits. They said nursing staff tried to make them as comfortable as possible.
- The community nurses referred to the specialist services such as end of life team to manage patients' pain if needed.

Nutrition and hydration

- Patients nutritional and hydration needs were assessed using the malnutrition universal screening tool. There was a clear action plan for patients who were nutritionally at risk, for example if supplements were not tolerated by the patient referral to the dietician was indicated.
- Patients identified with having swallowing difficulties were referred to speech and language therapists for swallowing assessment.

Technology and telemedicine

- Tele-monitoring technology was used for remote monitoring of patients with long-term conditions such as chronic obstructive pulmonary disease and heart failure. This was achieved through patient-recorded observations, such as pulse rate, blood pressure and oximetry, coupled with electronic responses to key questions.
- The dietetic service employed the use of tele-health to offer patients an alternative option for consultations.

Patient outcomes

- Patient outcomes were measured as part of the specific service performance metrics. This included participation in national audits.
- The Berkshire East and West pulmonary rehabilitation services contributed to the first National Chronic Obstructive Pulmonary Disease Audit Programme: Resources and organisation of pulmonary rehabilitation services in England and Wales 2015.This audit measured performance against quality standards. Both teams demonstrated good compliance with quality standards and identified a small number of areas for improvements. The clinical audit report for 2014/15 included the national chronic obstructive pulmonary disease, Sentinel Stroke National Audit Programme audit and Parkinson's audit. The trust registered for 157 local audits and completed 87.The clinical audit plan for 2015/16 included national audit of intermediate care and COPD.
- Three community teams participated in the Sentinel Stroke National Audit Programme (SSNAP) report for post-acute organisation audit for October 2015. Results showed response times for the early supported discharge team for stroke patients were better than the national average. The SSNAP report made recommendations, including on the multidisciplinary nature of team and ensuring that carers of people with stroke are provided with written information about the patient's diagnosis and management plan. They had sufficient practical training to enable them to provide care.
- The Berkshire West musculoskeletal service used a patient specific functional scale, which was a standardised outcome measure for patients self-reporting. The results for June to October 2015 showed an average 87% patients reported improvement in performance.
- The speech and language therapy service used standardised tools to monitor outcomes, for example, Grade Roughness Breathiness Asthenia Strain scale.
- The trust had services to provide intermediate care. This was to facilitate hospital discharge and prevent unplanned admission. They contributed to the National Audit of Intermediate Care (NAIC). Although it was acknowledged in, the 2014 report that 'minimal data was provided by Berkshire Health Care Foundation Trust for effective evaluation'. One of the issues was the relatively low (21%) number of teams that provided information on shared assessment frameworks and care plans. We reviewed the December 2015 provider report, which compared the performance of services that provided intermediate care provision nationally. It

reported that the time from referral to initial assessment for home based intermediate care services provided was longer than the national average of six days. It was between 10 and 14 days.

Competent staff

- Staff in all services said they had excellent opportunities for training. One community nurse said, "Training is fantastic." Another told us she was being supported to undertake the advanced clinical skills course. During a home visit, we observed one community nurse using advanced clinical skills to carry out examinations.
- Staff said they received support from peers and their managers through team meetings, one to one meetings and annual appraisals, where learning needs were identified.
- Overall data on the proportion of appraisals completed for staff in adult community services was not available. However, appraisal information was collated on individual teams. For example, the Berkshire community nursing scorecard for October 2015 showed staff appraisals at over 90%, which was above trust target of 85%.
- We saw attendance at clinical supervision took place every six to eight weeks on an individual or group basis. The community nursing attendance log for 2015 showed variable uptake. For example, some community nursing staff attended every eight weeks and other staff had no record of clinical supervision attendance since January 2015. The supervision attendance logs for specialist services and intermediate care staff showed high attendance rates.
- New staff in the musculoskeletal service said they were supported through induction, mentoring and monthly in-service training.
- Staff in the diabetic eye screening service, qualified as 'graders' were assessed monthly to ensure they were performing in line with accepted standards.

Multi-disciplinary working and coordinated care pathways

- Community nurses had good access to specialist teams, which facilitated effective multidisciplinary working.
- We observed three community nursing handovers, one of which also had a community matron in attendance. There was clear exchange of information, opportunity to obtain advice and discuss patients with peers before referring to other services. There was also handover of patients from the community matron to the community nursing team.
- Specialist nurses such as the tissue viability nurses were available for advice. When necessary joint visits took place, which was in line with the pressure ulcer pathway. Staff valued the input of the high technical specialist team for patients with complex needs who may benefit from specific equipment.
- The respiratory and heart failure nurses said they had direct access with the hospital cardiac and respiratory specialists to support them with patients care.
- A number of teams were, by their nature, multidisciplinary, to meet the needs of patients. For example, the diabetes team and the early supported discharge service for stroke patients. Staff in these teams said collaborative working amongst different professionals was very effective.
- In the records we reviewed, we saw evidence of good multi-disciplinary and multi-agency communication.
- Data showed that a range of referrals were made by the district nursing teams, the most common being to the community matron and end of life team.

Referral, transfer, discharge and transition

- The majority of referrals to community services that originated from external referrers were received into the trust via the 'Health Hub.' The exception to this were scheduled services in the West. The Health Hub acted as a single point of access to community services and was supported by clinical nurse advisors who triaged calls when necessary.
- Community nurses said there had been on-going issues with patients discharged from one local acute hospital, such as incomplete or inaccurate referral information, relating to medication or care needs. This issue had been raised with managers and the trust was in communication with the hospital to improve the situation.

Good

Are services effective?

- There were transition arrangements in place to support young people, who needed care, as they moved from children and young person services to the district nursing team.
- In East Berkshire a supportive discharge matron worked with hospital services to facilitate discharge.
- The musculoskeletal service followed a standard procedure to handover patients within the service. This ensured an effective transfer.

Access to information

- The community and mental health services used the same electronic patient record system. Staff said the ability to access the mental health records was a recent development and had significantly improved access to information and integration of the services.
- Although the electronic patient record system was in use, community teams continued to use a mixture of paper and electronic records. This was to ensure sufficient information was available in the paper record in the patient's home. This enabled visiting healthcare professionals to have a clear understanding of the patient's needs.
- Staff told us, and we observed, that connectivity to the electronic system was sometimes an issue, particularly when working outside of trust buildings and where internet connections were poor. This meant access to, and uploading patient information could be delayed. The system was being developed to allow staff to work "off-line"; they would be able to write their records at the time of the consultation and then have them reconciled to the system when connectivity was available.
- Some teams preferred to be more 'paper-light'. For example, we saw in West Berkshire a community nurse had a portable scanner and was able to scan a written assessment that was uploaded onto the computer and onto the patient's electronic record. The patient kept the paper copy in their home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions and seeking consent from patients, before providing care or treatment. Verbal consent to treatment was recorded in the patients' records. We observed that the nurse read out her notes for the patient, so they were informed before obtaining consent.
- Staff provided information and obtained written consent before photographs of a patient's wound were taken.
- Two out of five community nursing staff we spoke with in one of the teams in East Berkshire did not have a clear understanding of mental capacity. For example, they said they would ask relatives for consent if the patient was not able to give consent. One staff told us they would undertake an initial assessment and then refer to the memory clinic if needed.
- Data for October 2015 showed 86% of staff in adult community health services had Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training and 65% had dementia awareness training. However, in some teams, uptake was comparatively low. For example, in Windsor community nursing team, 11 out of 26 (42%) staff were overdue MCA and DoLS training.
- Staff in the rapid assessment clinic, had a clear understanding of their responsibilities under the MCA and were able to describe how it applied to their practice.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

Patients were treated with compassion and respect. Feedback from patients and their carers was consistently positive about the care they received and how staff treated them.

Patients were engaged in their care in a meaningful way. Staff spent time talking to patients, ensuring the information was presented in a way the patient could understand.

Staff cared for patients holistically and took into account of their physical and emotional needs. Group exercise sessions were held, so patients and carers could develop support networks.

Detailed findings

Compassionate care

- All the patients we spoke with praised the quality of care they received from staff. They told us staff were professional, caring and sensitive to their needs.
- Three different patients and one relative made the following comments: "They make me feel it's very personal to me", '' I am satisfied with the service I am getting'', ''the service I receive is excellent'', "My partner is having outstanding care from a wonderful team".
- Patients receiving care from the pulmonary rehabilitation service said, "Friendly and professional. …they made me feel very much at ease".
- Throughout our inspection, we saw patients being treated with respect and their privacy and dignity maintained whilst care was being provided.
- During home visits, we observed staff interactions with patients to be friendly and respectful. We observed sensitive and compassionate care provided to patients with complex needs and at end of life.
- During a cardiac rehabilitation session, we saw staff were able to engage with patients and facilitate a lighthearted atmosphere to encourage exercise.
- Patients valued the continuity of care and were reassured: "Every nurse that visits from the team seems to know exactly what has been said and done at last visit."
- Feedback for the rapid assessment clinic was 100% positive and 93% of patients who attended the continence advisory service rated their care as good or excellent.
- We spoke with two patients who attended the diabetic eye screening service. Both were positive about their experiences and one patient said "10/10 for staff support."
- The results of the Friends and Family Test survey for 1st April 2015 to 30th June 2015 showed 94% of users of adult community services would be extremely likely or likely to recommend the service they were seen by to friends or family. In October 2015, the results had improved to 100% of patients in the majority of services.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in their care. One patient receiving care from specialist nurses said "I feel I'm involved and in the driving seat, where I can make the choice."
- Patients participating in the cardiac rehabilitation programme said they were involved in setting their own goals from the outset. One patient said, "It's good, it makes you realise what you can do without getting frightened about over exertion." Patients told us and we observed, clear explanations were provided about care plans and treatment.
- We observed a patient receiving care from the early supported discharge service who gave positive feedback on the programme of exercises they had followed and the improvements shown. We saw staff listened to patient concerns and provided onward advice about the support available.

Good

Are services caring?

- We saw one community nurse involved the patient when ordering equipment and clearly explained the need and potential benefits.
- Patients said they were given sufficient verbal and written information about their care and treatment.
- Patients were always provided with the opportunity to ask further questions at the end of their assessment, both during home visits and at outpatient clinic appointments. Patients said they were listened to and were able to express concerns they had.
- Patients cared for by the district nurses, in general, knew how to speak to a member of staff in an emergency or who to contact outside the normal working hours of the service. We observed a patient being given contact details as part of their first visit by the district nurse.
- One patient who attended the diabetic eye screening service said care was explained to them and they had been given leaflets to read at home.

Emotional support

- We observed that patients were provided with holistic care, their personal wellbeing and emotional state was considered. A patient was visibly upset due to the length of time taken for their wound to heal. The nurse took time to reassure the patient through further assessment and demonstrated an empathetic and professional approach.
- A patient who was particularly appreciative about the community nurses, who had provided their care for over a year said; “They are more like trusted friends… so understanding….been my lifeline.”
- We saw patients who attended the cardiac rehabilitation programme had requested input from the talking therapies service and this had been arranged as part of the educational component of the programme.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

Services were developed to meet the needs of the community in the local area. A number of services had recently been reconfigured to become integrated and responsive to patients with complex conditions.

Services were planned and delivered in a way that met the needs of the local population. Patients were seen at home and in outpatient clinics which were provided countywide. Services had made changes in response to patient feedback, including access to appointments, at a time, which was convenient to the patient.

Staff were mindful of the need to ensure their service was accessible for all and we saw good examples of how patients who were non-English speaking, had a disability, or were living with dementia, were supported. Care plans were co-ordinated across different services. Clinics were held in locations, which were accessible to all.

The directorate were working with other health and social care providers in the area to reduce the number of delayed transfers of care.

Complaints were handled in line with the trust's policy and were dealt with in a timely manner. Staff received feedback from complaints in which they were involved and learning was shared at team meetings.

Detailed findings

Planning and delivering services which meet people's needs

- The trust operated in a complex commissioning environment, with six local authorities and seven clinical commissioning groups. The trust operating plan for 2014-16, identified priorities such as improving services for people with dementia and diabetes, in line with the local priorities. It also highlighted the development of collaborative community pathways of care to provide enhanced out of hospital care. This was evident in some of the teams we visited which had recently been reconfigured, such as the integrated intermediate care team, rapid assessment clinic and the cardiac and respiratory service.
- The integrated intermediate care team in West Berkshire locality had recently reconfigured and its aim was to facilitate hospital discharge and prevent unplanned admission to hospital, by providing urgent assessment, short-term care input and urgent equipment provision.
- The assessment and rehabilitation clinic was a one-stop shop. It provided multidisciplinary clinics for falls and Parkinson's disease. It aimed to provide a responsive and patient centred service of interdisciplinary medical, nursing and therapy professionals.
- A joint physiotherapy, speech, and language therapy group for Parkinson's disease patients provided intensive therapy. A patient's partner who had seen an improvement in health said "gets us out moving and conversing."
- The early supported discharge service for stroke patients aimed to see patients within one day of referral and provide six weeks of intensive rehabilitation in line with the National Institute for Health and Care Excellence guidance.
- The heart failure, respiratory and cardiac rehabilitation specialist services had all recently merged into one service to become the cardiac and respiratory specialist services. Staff in the new service had recently co-located and were developing a more integrated approach.
- The East Berkshire diabetes service had developed a gestational diabetes education session to meet the specific needs of the population, where there was a higher than average prevalence of gestational diabetes.
- The continence advisory service had reviewed its provision in response to its waiting times and developed group education and exercise sessions to improve access for women. The service had received positive feedback from patients. It was nationally recognised as an exemplar of good practice.

Good

Are services responsive to people's needs?

- The West Berkshire musculoskeletal service had increased its opening hours. Treatment times allowed patients to attend appointments before work if they preferred, from 7.30am and also on Saturday mornings.

Equality and diversity

- Staff told us how they planned services to ensure they were accessible to all. This included holding clinics at locations, which were accessible to people with a disability.
- Equality and diversity training for staff was part of the mandatory training programme. However, the staff survey results showed the trust was in the bottom 20% of trusts for percentage of staff who had received equality and diversity training. The trust had a plan in place to improve the situation and staff did not show a lack of awareness in this area.
- An information booklet on religions and cultures in Berkshire was available. This gave staff an awareness of how to behave when visiting or providing care and treatment in a culturally appropriate manner.
- Interpreting services were available and staff said they booked an interpreter if needed and occasionally rescheduled appointments if it had not previously been identified an interpreter was needed.
- Patient information, including exercise sheets was available in different languages to suit patients' needs.

Meeting the needs of people in vulnerable circumstances

- The musculoskeletal service in West Berkshire offered home visits for patients with a learning disability to meet their needs in a more suitable environment.
- The continence advisory service offered patients with a learning disability, individual appointments as opposed to group sessions, to ensure they received the right level of support.
- The trust had developed resources for people with dementia including memory clinics and a booklet to support carers of patients with dementia.

Access to the right care at the right time

- The majority of referrals to community health services were directed through the 'Health Hub'. The trust monitored waiting times for treatment, which showed that between 1 January 2015 and 31 March 2015, all services had met the national and local targets.
- The community nursing team saw urgent referrals within 4 hours. Data for October 2014 and September 2015 for East Berkshire showed an average wait to first appointment from referral for community nursing was less than 2 weeks, physiotherapy musculoskeletal 2.8 weeks, speech and language therapy 4.8 weeks, intermediate care 5 weeks and continence advisory service was 10.4 weeks.
- Data for West Berkshire for the same period showed average wait for community nursing was less than one week, speech and language therapy was 5.1 weeks, intermediate care 2.8 weeks, West Berkshire musculoskeletal 4.1weeks and continence service was 6.6 weeks.
- The cardiac and respiratory service did not operate a waiting list. They provided rapid access for patients within 2 hours and 5 days for non-urgent referral.
- The intermediate care service aimed to respond within 2 hours to prevent a patient's admission to hospital. Staff said when the service was not able to meet demand, new referrals were not accepted and this was reported as an incident. Difficulties in organising social care packages for patients led to delays in discharge from hospital.
- The trust reported on the number of avoidable emergency admissions to hospital as part of the NHS commissioning for quality and innovation scheme (CQUIN). For the period 1 April 2015 to 30 June 2015, 100% of urgent referrals were seen within 2 hours for the rapid response team and 99% of urgent referrals were seen within 2 hours by the community nursing service.
- The diabetic eye screening service was performing above its targets, for example, 94% patients for urgent referrals were seen within four weeks (target 80%) and 99.9% of patients were informed of their test results within three weeks.

Learning from complaints and concerns

- Staff provided patients with information at their initial assessment on how to complain. Complaint information

Good

Are services responsive to people's needs?

was on display in clinics and hospitals for patients to access. Patients we spoke with said they never had cause to complain, but most recalled a leaflet or being informed about their rights to complain.

- Staff were aware of how to respond to complaints and concerns. The service manager was responsible for investigating complaints unless it was more appropriate for the investigation to be conducted external to the service.
- When there was a need for improvements or changes, an action plan was produced which contained recommendations, actions and target dates for completion. Complainants received a response in writing, which includes an invitation to contact the trust again if they are dissatisfied with the response.
- The sharing of learning from complaints took place at team meetings. The trust recently introduced a bulletin, 'learning curve', to share learning from incidents and complaints.
- Staff were aware of changes to procedures, for example, appointment system and the introduction of e-referrals, following complaints by patients.
- For the period August 2014 to July 2015, 37 complaints were received by community health services for adults. Of these, eight were upheld by the trust; there were no complaints that were referred to the Ombudsman.
- The director of nursing presented a quarterly patient experience report to the trust board. This included an analysis of complaint response times and themes identified. For the period July 2015 to September 2015, five complaints had been received relating to the district nursing/ community matron service, this was out of 145 complaints. There were no specific trends identified from complaints about the community adult services.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good.

There was good local leadership provided throughout the teams and services we visited and staff were very positive about the support they received from their team leaders and managers.

Clear management and governance structures were in place through meetings to monitor performance and service risks.

There was a clear vision and strategy in place for community health services for adults, in line with the trust vision and goals. Most teams had developed their own business plans to correspond with the trust goals.

Quality performance was monitored and reported at board and directorate level, with action taken in response to areas of poor performance. There were local risk registers in use and teams discussed safety performance at their team meetings. Audits were used to monitor performance and improve quality. Policies and standard operating procedures were in use, but we found some of these to be out of date.

Patient feedback was collected and used in make changes to a number of the services we visited. These included patient survey feedback and learning from complaints.

There were good examples of innovation to improve patient care and wellbeing. Cost improvement programmes were in use to ensure sustainability of services.

Detailed findings

Service vision and strategy

- Service managers in the community health services for adults were clear about their priorities and strategic plans. Staff understood the trust vision and values.
- Service leads and staff were knowledgeable about the clinical areas in which they operated.
- Service business plans for 2015 were known as a 'plan on a page' and these were on display in offices. These showed the five trust strategic goals and expected individual team objectives to be aligned with these goals. For example, under goal 3 'be the provider of choice for people who use and commission our services', West Berkshire community service had 'securing the contract for musculoskeletal services in the West of Berkshire.' Another example was the East Berkshire musculoskeletal service, which had under goal 4, 'establish a comprehensive range of integrated 'out of hospital' services and 'continue linking in with the west physiotherapy service to ensure consistency across teams and shared learning'.

Governance, risk management and quality measurement

- A number of services in community health services for adults had undergone change. This included the community nursing teams, rapid response, heart failure respiratory and cardiac rehabilitation. Changes included relocation and/or reconfiguration of teams and management changes. During this transition, the trust provided additional support to the teams, such as peer support, coaching and additional development time. This also included away days to facilitate the change process and reduce risks to the service. The senior managers had provided stability through this period. Generally, we found staff were positive about the way change was handled and they said they were optimistic for the future.
- Community teams had regular meetings where information was shared and issues escalated to the locality patient and safety quality (PSQ) group. This group met monthly and considered the issues for each of its services. It was chaired by the locality clinical

directors. Information from this group was provided to the quality executive group (QEG) which was chaired by the chief executive and attended by each locality and clinical director. Minutes of the meetings showed that concerns were escalated, followed up and feedback was provided. The QEG of 14/09/15 highlighted 10 inappropriate discharges from a local acute hospital, reported by the Windsor and Maidenhead (WAM) PSQ. The minutes of the WAM PSQ for 25/11/15 showed a meeting had taken place with senior staff at the acute hospital to improve the situation. Another example identified in Bracknell related to staffing issues and measures managers had taken to mitigate the impact of staffing problems. The following month's QEG minutes provided an update on the staffing situation in Bracknell.

- Risks were discussed at team meetings and captured on a risk register. Some teams recorded their risks on a team register, for example, Windsor and Maidenhead district nurses. Others logged issues directly on the locality risk register, for example in Reading. Staff we spoke with were not always clear how frequently risks were monitored and managed and when they were removed from the register.
- The community nursing service had a scorecard to collate performance and safety issues and this was discussed at locality meetings.
- The trust audit plan was monitored at the audit committee. Audit findings and action plans were discussed at the quality executive meetings and locality meetings.

Leadership of this service

- Each team or service had a team leader who provided day-to-day operational management. The team leads were managed by locality managers. All staff told us their team leads and service managers were supportive and would raise concerns on their behalf.
- Staff were well supported by their line managers and felt their role was valued by senior management.
- The trust supported staff to develop leadership and management skills. For example, all band seven and above staff would be enrolled on the trust management course.
- Where leadership or management issues were identified individual staff and teams were supported to seek resolution.
- Managers listened to their staff concerns or suggestions and escalated these when appropriate.

Culture within this service

- Staff described an open culture where they were confident to raise concerns with their managers or more senior if needed. One staff said about the managers "genuinely care and 'don't want to hide things."
- Staff spoke about their value, which were consistent with those of the organisation. We saw that staff were dedicated and that they placed strong emphasis on supporting patients to be independent at home and avoid hospital admission.
- Staff were provided with lone worker alarms and took appropriate precautions, for example, at night they conducted visits in pairs and if there were known risks about a patient or family.
- During our inspection and visits to a range of teams staff showed professional respect for colleagues and placed value on collaborative working.

Public engagement

- Patients' views were captured through surveys, complaints and compliments. All services obtained feedback from patients, through the Friends and Family test or through specific surveys. There was a high level of patient satisfaction.
- The trust participated in the 'listening into action' change management initiative, which engaged with staff and patients to effect change. One outcome of this resulted in the introduction of text reminders for patients to reduce non-attendance at appointments.
- An example of changes that had been introduced, in response to patient complaints included better information about booking appointments for the musculoskeletal service.
- Data on complaints and accolades for the directorate was reported on a monthly basis at the locality meetings and quality executive group. This was shared with the board.

Staff engagement

Good

Are services well-led?

- The trust was proud of four consecutive years of improved feedback from staff in the NHS staff survey results. This positioned the trust in the top 20% of mental health NHS trusts. The Friends and Family Test results for April 2015 to June 2015 results showed 68% of staff would recommend the trust as a place to work, which was also above the national average of 63%.
- Staff said that when they raised concerns, the concerns were addressed. For example, staff in one team said the trust had listened to their concerns about travel time. Subsequently they had been provided with a base near the area they worked. Another team said that a suggestion to provide community nurses with scanners and printers to improve record keeping had been implemented.
- Staff told us where two teams had relocated to the same site, there were initial tensions in the different working practices. However, this had been acknowledged and support was provided to resolve differences.
- Information was shared with staff electronically in newsletters and the intranet, as well as face-to-face and at team meetings. We saw from the notes of the Bracknell district nurse forum, that an issue had been raised, where designated staff to authorise equipment orders had not been available. This was due to staff leaving and this was recognised needing urgent resolution.

Innovation, improvement and sustainability

- The adult community services were working to implement the 2015/16 cost improvement plans. For example, to improve mobile working for staff in order to increase productivity. Service reviews had taken place to move towards more integrated and resilient services to improve sustainability.
- Innovation was encouraged, for example, the continence advisory service had introduced group sessions, which reduced waiting times and resulted in positive patient feedback. The service was recognised nationally as an example of best practice.
- Staff were empowered to share ideas and develop evidence-based models of care. For example, the early supported discharge service for stroke patients, and the intensive multidisciplinary clinic for patients with Parkinson's disease.